TEXAS Health and Human Services | Texas Department of State Health Services

Highly Pathogenic Avian Influenza A (H5N1) Case Investigation Form

For use by health departments to investigate human infection with avian influenza virus (H5N1) associated with the Emerging Health Event in the U.S in March 2024.

Local health departments should email/fax the completed form to their Public Health Region (PHR).
DSHS PHRs should send completed forms through secure email to DSHS EAIDU at FLUTexas@dshs.texas.gov.

DEMOGRAPHIC INFORMATION

***Reporting health department:**	**Investigator name** (last, first)**:**	**Investigator Email:**		**Investigator Phone:**
Case Name (last, first):	**Date of birth:**	**Age:**	**Sex:**	**Case Email:**
Address (street address, city, zip)**:**	**County of residence:**			**Case Phone:**
Race ☐ Asian ☐ American Indian/Alaskan Native ☐ Black or African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Unknown ☐ Other: _____	**Ethnicity** ☐ Hispanic ☐ Not Hispanic ☐ Unknown			***Case Status** ☐ **Suspect** ☐ **Probable** ☐ **Confirmed** ☐ **Lost to Follow-Up**
***Date of report (mm/dd/yyyy):** **To Public Health:** ___/___/___ **To State:** ___/___/___	**Reporter:** **Reporter Phone:**			**NEDSS ID/Unique ID:**

LAB INFORMATION

Specimen Collection Information (Select all that apply)

*Specimen Type	*Test Type	*Collection Date	*Result
☐ Nasopharyngeal (NP) swab (recommended)	☐ RT-PCR ☐ Unknown ☐ Rapid antigen ☐ Other _____	___/___/___	☐ Positive ☐ Equivocal ☐ Negative ☐ Not Tested
☐ Oropharyngeal (OP) swab	☐ RT-PCR ☐ Unknown ☐ Rapid antigen ☐ Other _____	___/___/___	☐ Positive ☐ Equivocal ☐ Negative ☐ Not Tested
☐ Nasal aspirate or wash	☐ RT-PCR ☐ Unknown ☐ Rapid antigen ☐ Other _____	___/___/___	☐ Positive ☐ Equivocal ☐ Negative ☐ Not Tested
☐ Ocular swab (recommended if conjunctivitis is present)	☐ RT-PCR ☐ Unknown ☐ Rapid antigen ☐ Other _____	___/___/___	☐ Positive ☐ Equivocal ☐ Negative ☐ Not Tested
☐ Other	☐ RT-PCR ☐ Unknown ☐ Rapid antigen ☐ Other _____	___/___/___	☐ Positive ☐ Equivocal ☐ Negative ☐ Not Tested

LAB INFORMATION CONTINUED

Where was test performed? ☐ State public health laboratory ☐ Other:_____ ☐ Unknown

***If test result was positive, please indicate virus identified (select all that apply):**

☐ Influenza A ☐ Influenza B ☐ Influenza A/B (type not distinguished) ☐ Influenza A (unsubtypeable)

☐ Influenza A (H5 Unknown N) ☐ Influenza A (H5N1) ☐ Negative ☐ Other:_____

☐ Unknown

Subtype/Lineage/Clade/Sub-Clade (if known): _____

CLINICAL INFORMATION

1. ***Date of illness onset**: ___/___/_____
2. ***Was person hospitalized for this illness?**

☐ Yes ☐ No ☐ Unknown

2b. *Facility name/location: _____

_____

2a. *Date of admission: ___/___/_____

2c. *Date of discharge*: ___/___/_____ or

☐ Still Hospitalized

3. **Did patient seek care in an outpatient setting (e.g., primary care physician, ER, urgent care)?**

☐ Yes ☐ No ☐ Unknown

3a. Facility Name: _____

3b. Provider Phone Number: _____

3c. Date of Visit:___/___/_____

4. **Was the patient vaccinated against seasonal influenza since August 2023?**

☐ Yes ☐ No ☐ Unknown

5. **Has the patient been isolated?**

☐ Yes ☐ No ☐ Unknown

5a. If yes, type of isolation:

☐ Self-isolation at home (including the use of a face mask at home, when around others)

☐ Isolated at hospital (ensure infection control precautions: https://www.cdc.gov/flu/avianflu/novel-flu-infection-control.htm)

☐ Other: _____

5b. Isolation Start Date: ___/___/_____

5c. Isolation End Date: ___/___/_____

6. ***Did patient die?**

☐ Yes ☐ No ☐ Unknown

6a. If yes, died on: ___/___/_____

6b. Did patient die from HPAI (H5N1)?

☐ Yes ☐ No ☐ Unknown

7. ***Symptoms:**

7a. Fever (≥100°F)/ feverish	☐ Yes	☐ No	☐ Unk
7b. Highest temp recorded (°F)	_____		
7c. Date of fever onset:	___/___/_____		
7d. Diarrhea	☐ Yes	☐ No	☐ Unk
7e. Cough	☐ Yes	☐ No	☐ Unk
7f. Nausea	☐ Yes	☐ No	☐ Unk
7g. Sore Throat	☐ Yes	☐ No	☐ Unk
7h. Vomiting	☐ Yes	☐ No	☐ Unk
7i. Runny Nose	☐ Yes	☐ No	☐ Unk
7j. Myalgia	☐ Yes	☐ No	☐ Unk
7k. Rash	☐ Yes	■ No	☐ Unk
7l. Headache	☐ Yes	☐ No	☐ Unk
7m. Conjunctivitis/eye infection/eye redness	☐ Yes	☐ No	☐ Unk
7n. Shortness of Breath	■ Yes	☐ No	☐ Unk
7o. Fatigue/malaise	☐ Yes	☐ No	☐ Unk
7p. Seizures	☐ Yes	☐ No	☐ Unk
7q. Other	☐ Yes	☐ No	☐ Unk
7r. Date of Illness Resolution:	___/___/_____		

TREATMENT INFORMATION

8. Did this patient take influenza antiviral chemoprophylaxis due to prior exposure?

☐ Yes ☐ No ☐ Unknown

8a. If yes, date started: ___/___/_____

8b. If yes, was chemoprophylaxis completed?

☐ Yes ☐ No, became ill before course was completed

☐ No, nonadherent ☐ Unknown

8c. If yes, what chemoprophylaxis was taken? _____

9. *Has this patient started influenza antiviral treatment (for symptoms)?

☐ Yes ☐ No ☐ Unknown

9a. If yes, select which treatment:

☐ Oseltamivir (Tamiflu)

☐ Zanamivir (Relenza)

☐ Other influenza antiviral: _____

9b. If yes, date started: ___/___/_____

MEDICAL HISTORY

10. *Does the patient have any of the following chronic medical conditions?

(If none, proceed to question 11)

☐ None ☐ Asthma/reactive airway disease ☐ Other chronic lung disease ☐ Chronic heart or circulatory disease

☐ Diabetes mellitus ☐ Kidney or renal disease ☐ Non-cancer immunosuppressive condition

☐ Cancer chemotherapy in past 12 months ☐ Neurologic/neurodevelopmental disorder ☐ Other chronic diseases

For selected condition(s), please explain below:

11. *Was patient pregnant or ≤ 6 weeks postpartum at illness onset?

☐ Yes ☐ No ☐ Unknown ☐ Not applicable

11a. If yes (pregnant), weeks pregnant at onset? _____

11b. If yes (postpartum), delivery date: ___/___/_____

EPIDEMIOLOGY INFORMATION

Communicable Period: Illness onset date: ___/___/_____ → **10 Days Prior:** ___/___/_____

Travel:

12. Did the patient travel outside of their county of residence in the 10 days before onset?

☐ Yes ☐ No ☐ Unknown

12a. If yes, specify: _____

EPIDEMIOLOGY SECTION (CONTINUED)

13. In the 10 days prior to illness onset, did the patient consume, touch, or handle any raw milk or raw milk products?

☐ Yes ☐ No ☐ Unknown

13a. Type of product (select all that apply)

☐ Raw milk ☐ Cheese made from raw milk ☐ Dairy products made from raw milk ☐ Other: _____

13b. If yes, where was the raw milk/product obtained: _____

14. In the 10 days before becoming ill, did that patient have contact (DIRECT or CLOSE) with any animals?

If no, proceed to question 17

Please complete the table below by checking off the type of contact the patient had with each animal listed (or write in other animals, if not listed).

Note: *Contact with animals including but not limited to livestock such as cows, poultry, or pigs.*

- ***DIRECT*** *Contact: touch or handle animals*
- ***CLOSE*** *Contact: within 6 feet of animals for a combined total of 15 minutes or more*

Animal	**NO** Contact	**DIRECT** Contact	**CLOSE** Contact	**Did animal appear ill?** (If yes, proceed to 14a)	**Date of Contact**
Cows	☐	☐	☐	☐ Yes ☐ No ☐ Unk	__/__/____
Poultry	☐	☐	☐	☐ Yes ☐ No ☐ Unk	__/__/____
Sheep	☐	☐	☐	☐ Yes ☐ No ☐ Unk	__/__/____
Goats	☐	☐	☐	☐ Yes ☐ No ☐ Unk	__/__/____
Pigs	☐	☐	☐	☐ Yes ☐ No ☐ Unk	__/__/____
Other: _____	☐	☐	☐	☐ Yes ☐ No ☐ Unk	__/__/____
Other: _____	☐	☐	☐	☐ Yes ☐ No ☐ Unk	__/__/____
Other: _____	☐	☐	☐	☐ Yes ☐ No ☐ Unk	__/__/____

14a. If animal appeared ill, please describe below the type of contact, animals contacted, and location.

EPIDEMIOLOGY SECTION (CONTINUED)

15. In what type of setting did contact (DIRECT or CLOSE) with animals occur? (For any area other than patient's home, write business name and address or city.)

Business name Address City/State						
Animal	**Patient's Home**	**Agriculture Fair**	**Live Animal Market**	**Petting Zoo**	**Work** (If contact occurred at work, proceed to 15a and 15b)	**Other Setting** _____
Cows	☐	☐	☐	☐	☐	☐
Poultry	☐	☐	☐	☐	☐	☐
Sheep	☐	☐	☐	☐	☐	☐
Goats	☐	☐	☐	☐	☐	☐
Pigs	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐

15a. If contact occurred at work, describe your job duties:

If patient works at a dairy farm, complete the table below. If not, **proceed to question 17.**

15b. Did contact (DIRECT or CLOSE) occur in any of the following areas at the dairy farm? If the patient had NO contact with animals in the location, select the NO contact box.

Location at Dairy Farm	**NO** Contact	**CLOSE** Contact	**DIRECT** Contact
Milking Parlor	☐	☐	☐
Milk House	☐	☐	☐
Hospital/Sick Pens	☐	☐	☐
Calf Milk Handling/Feeding Facilities/Pens	☐	☐	☐
Lab Testing/Sampling	☐	☐	☐
Milk Load Outs from the dairy into milk tanker	☐	☐	☐
On Farm Milk Tank Washing Facilities	☐	☐	☐
Reproductive Pens	☐	☐	☐
Maternity Pens	☐	☐	☐
Animal Yard/Open Pen	☐	☐	☐
Feed Handling	☐	☐	☐
Other: _____	☐	☐	☐

16. Select all PPE the patient wore during the contact with animals?

☐ No PPE worn ☐ Goggles ☐ Gloves ☐ Boots/boot covers ☐ Respirator (e.g. N95) ☐ Disposable Coveralls
☐ Disposable hair/head cover ☐ Other: _____

17. In the 10 days prior to becoming ill, did the patient have close contact with anyone who works on a farm and/or who routinely handles livestock?

☐ Yes ☐ No ☐ Unknown

If yes, please provide the following:

	Name	Physical Address	Phone
Farm Contact Information			
Close Contact Information			

18. Is the patient a contact of someone who has tested positive for novel influenza virus A infection?

☐ Yes ☐ No ☐ Unknown **If yes, complete the table below:**

Relationship to Patient	NEDSS/Unique ID	Sex (M/F)	Age	Date of Illness Onset
				/ /
				/ /
				/ /

19. Is the patient a contact of someone who was sick with an influenza-like illness and/or conjunctivitis within 10 days of illness onset?

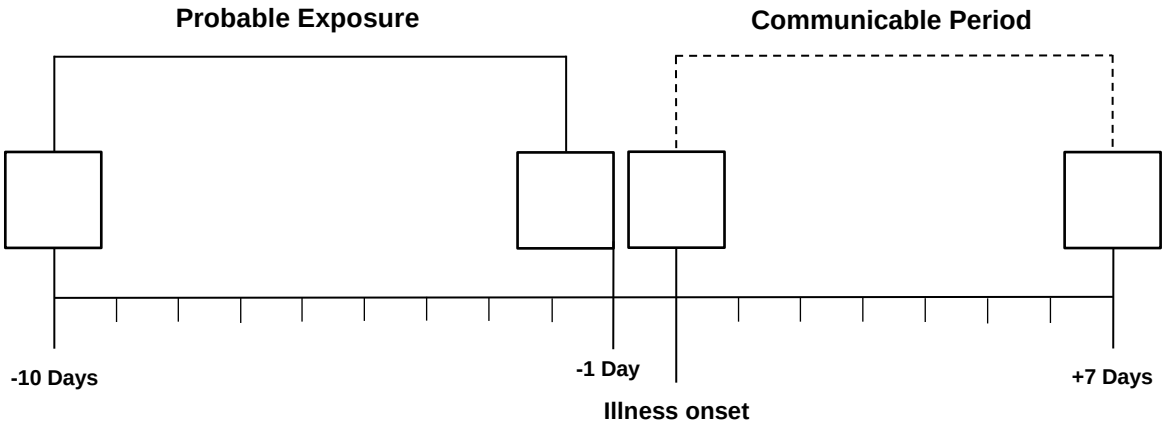
☐ Yes ☐ No ▣ Unknown

If yes, please provide the following:

19b. Contact Name: _____ Contact Address: _____ Phone: _____

20. INFECTION TIMELINE:

Enter onset of illness. Count backwards and forwards to enter dates to probable exposure and communicable periods.



INFECTION TIMELINE (CONTINUED)

Identified Contacts

Initials	Relationship	Sex (M/F)	Age	Symptomatic (Y/N)	Illness Onset	Did They Have Animal Exposure (Y/N)	Date PEP Recommended by Public Health	Date PEP Started

Notes/Comments: Add additional information or contact information –

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Local health departments should email/fax the completed form to their Public Health Region (PHR).

DSHS PHRs should send completed forms through secure email to DSHS EAIDU at FLUTexas@dshs.texas.gov.

- Antiviral treatment should be given to all patients with possible infection with novel influenza A viruses. Local health departments should encourage persons with possible infection or who have tested positive for avian influenza A (H5N1) to discuss antiviral treatment with their healthcare provider.
- Healthcare facilities should use appropriate isolation precautions for patients for infection with novel influenza A viruses. Persons with possible infection or who have tested positive for avian influenza A (H5N1) should stay home from school, work, and social gatherings until cleared by public health.